

Return completed form, within three (3) working days, to
TSD/NCB/Security Operations Unit, 1400 Broadway Rm B204, Helena MT 59620 or FAX 444-5924

NON-DPHHS Employee System/File Access DELETE Request

Name of Individual Requiring Deletion of Access: _____

(Please Print)

Phone: _____

Logon ID: _____

Employer: _____

Address: _____

E-mail: _____

Please delete all access effective: Date and time deletion should take effect

Reason for termination of access:

Signature of Employee: _____ Date: _____

Supervisor: Access for this individual is allowed for six months. I realize I will have to contact the DPHHS Security Officer if this employee needs access beyond the six months. I understand that it is my responsibility to inform the DPHHS Security Officer immediately when this employee terminates or no longer needs access.

Print Name of Supervisor: _____

Signature of Supervisor: _____ Phone: _____ Date: _____

Data Owner: _____ Phone: _____ Date: _____

Security Officer: _____ Date: _____